VOL. 13, NO. 4 NOV.-DEC., 1963

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

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N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Department of Mental Health. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay if the patient is able to pay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, one other physician, a psychiatric social worker, psychologist, chaplain and admitting officer, vocational rehabilitation counselor, activities director, and a full attendant staff.

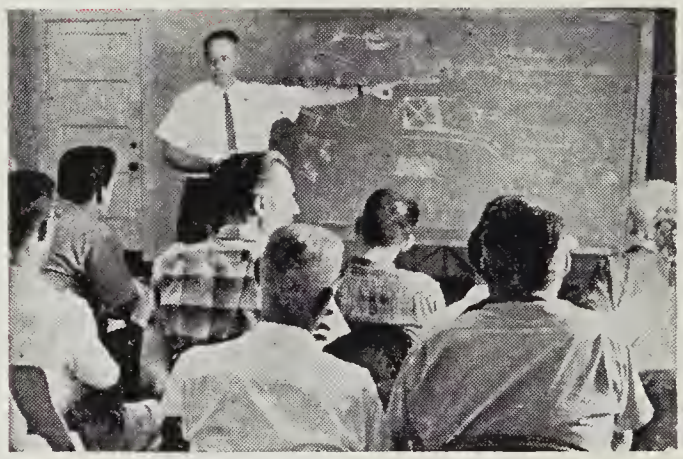
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician, are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission if the patient is able.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00-4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

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ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912

Editor's Note: Dr. E. M. Jellinek died in his office shortly after noon October 22. He had not appeared to be in ill health. During the morning he had been actively working on several projects, and at lunch he discussed with other staff members the question of motivating the alcoholic to seek treatment. The end came so suddenly that he was conscious for only a few moments. Before emergency treatment could arrive, he was dead.

A simple memorial service was held Sunday, October 27, 1963 at 4:00 P.M. in the Stanford University chapel with Dr. Joseph Katz giving the tribute which is published here.

TRIBUTE TO DR. E. M. JELLINEK

We have come here to honor and to express our affection for the memory of Professor Jellinek. Professor Jellinek is universally recognized as "the foremost protagonist of progress" in the scientific study of drinking and alcohol problems. Much of what the world knows today about the nature of drinking and alcoholism is due to his astoundingly rich work. It includes his discoveries of the species of alcoholism, the phases of drinking, the surveys of drinking patterns and attitudes in almost every country of the world. But in his monumental enlargements of our knowledge, his attention was forever fixed on the human problems and the human suffering caused by alcohol. He strove incessantly to make the lay and the professional public understand that the alcoholic is not a hopeless misfit, but a human being afflicted with an illness to which an end can be put if it is treated in an appropriate manner. It is in this spirit that he established the Yale Plan Clinic which was to serve as a model for treatment centers everywhere. His scientific and practical activities are too numerous to mention. They include his research directorship at Yale, his editorship of the *Quarterly Journal of Studies on Alcohol,* his long work with the World Health Organization in Switzerland, his chairmanship of the board of directors of the National Council on Alcoholism, his membership on the Cooperative Commission on the Study of Alcoholism, his work with us at the Institute for the Study of Human Problems at Stanford. Professor Jellinek not only had an unequaled fund of knowledge but a singular talent for evoking tolerance among clashing viewpoints. He was beloved by people with sharply conflicting philosophies about drinking and he was always ready to counsel those whose lives had been adversely affected by alcohol.

Professor Jellinek came to give major attention to the problems of alcohol only in the last 25 years of his life. Before that he was engaged in far-flung researches in physiology, biology, botany, statistics, psychiatry—researches that carried him to the four corners of the earth and to work done at times at great personal deprivation. We at the Institute have come to share Professor Jellinek's bright memories of his long student years in Europe during which there was no province of human knowledge that was alien to his curiosity—a background that enabled him to bring to his understanding of alcohol problems his knowledge of ancient and modern philosophy and literature as well as that of modern science. Professor Jellinek at any time could have occupied a professorship of classics and history with equal brilliance and grace with which he occupied his professorships of psychiatry. He was equally at home in Grenoble, Leipzig, Budapest and the jungle. It was during his biological researches in Africa that his attention was first directed to alcohol when associates of his with drinking problems came to him for counsel.

In almost two years that it was our singular good fortune to work with Professor Jellinek at our Institute, he was to us an inspiring model every day of pure scientific curiosity, dedication, and integrity. He made us feel that the straightforward pursuit of knowledge was one of the temptations of the marketplace and of the greatest joys of man against which easy compromise and status paled into nothing. But the impact of E. M. Jellinek the scientist is inextricably linked for us with the impact of the man. His enthusiasm for thinking was matched by the warmth he felt for people and the warmth he inspired in them for him. People took to him on first sight. He almost instantly asked us to call him "Bunky," the name his father had given him when he was a little boy. He showered us with gifts of his light-hearted verse and nonsense rhymes, or parodies of ancient mythologies. His whimsical humor, including his poking fun at himself, were gifts every day. He was open to any experience. We will never forget his slow walk in the rain, for that, too, was an experience he liked to savor. His walk, his gestures, the roundish contours of his body are forever enshrined in our memory and the image of this giant in a small body will be forever vivid with us. Bunky easily switched from the language of the learned to that of little children whom he told stories about his two imaginary brothers, Donkey and Monkey. Children easily recognized him as one of their own kind in the vitality of his spirit. Bunky's greatness owed much to his having preserved throughout his life the fresh curiosity of the child and this is evident in the last scientific notes he dictated on the morning of his death. In his scientific pursuits he retained the child's zest for play. Like the child, too, he despised pomposity and falseness.

We will miss Bunky greatly and the pain over his sudden death is sharp—he died in the midst of work and youthful in everything but years. But into our sorrow mingles our gratitude for having lived close to him for two short years. Bunky spurned big words. But he always did answer our readiness to be inspired by his example and, above all, our love for him.

ALCOHOLISM— A COMMUNITY RESPONSIBILITY

BY THOMAS JONES, M.D.

MEMBER, DURHAM COUNCIL
ON ALCOHOLISM

This speech is published by permission of the author, a Durham, N. C. general practitioner and a member of Durham's Council on Alcoholism. It was given at the annual meeting of the Charlotte, N. C. Council on Alcoholism in the summer of 1963.

The manner in which a community copes with the problem of alcoholism is an indication of its social conscience and its capacity to discharge its responsibility.

ALCOHOLISM is a subject about which most of us are anything but open-minded or objective. It will be no surprise if this discussion leaves some of you with a stronger conviction than ever that the alcoholic should be punished, and that better means should be devised to control him or separate him from society. Others, hopefully, will see a bit more clearly the community responsibility in all areas of concern for the alcoholic as he exists and affects his total environment.

In short, the question is whether this discussion will add to your preconceived opinion or prejudice, or to your knowledge about alcoholism and your desire to implement a constructive approach to a community problem.

The colossal dilemma for both alcoholic and community is the terrifying urgency of *now* set in a continuum of individual and cultural eternity. The alcoholic has his problem for his lifetime. The community has this complex cultural problem for its duration.

The manner in which the alcoholic handles his problem reveals his awareness of personal need, his honesty with himself, and his determination to do something about it. The manner in which the community handles the total problem is the barometer of its social conscience and its capacity to marshall its resources for practical and effective discharge of its responsibility.

The sum total of our knowledge is prodigious education in the known and research into the unknown which is going on in ever-expanding programs and projects. Much is known of parental influence and environment which may contribute to the development of a personality vulnerable to the addictive potential of alcoholic beverages. The progress of the alcoholic-to-be can be charted with disturbing accuracy through years of broadening social and interpersonal relationships, the early manifestations of loss of control in drinking, and the significantly well-known criteria for the diagnosis of actual alcoholism.

The community, whether aware of it or not, is seriously concerned and

involved all the way. While community resources in so many ways are used and are of tremendous importance in the pre-alcoholism existence of the individual and his family, with or without awareness of the alcoholism-problem-to-be, the greatest and most urgent need for engagement of total community resources and ministry of special services comes into focus when the alcoholic is actually identified and his needs become more or less obvious to all.

Community responsibility most often begins with the dawning awareness that something should be done about the problems of alcoholism. This naturally leads to the need for definition, understanding, recognition, identification, or total appreciation of the actuality and factuality of this major public health problem. Education in the fertile field of social curiosity and community concern is emphasized by all agencies dedicated to work in this area. Coordination of aim and action by existing social services is healthy and important for the community. Awareness of, and utilization of, the specific resources of help for the alcoholic and his family that are already available and proven in relative effectiveness, should be as promptly considered as a call to the fire department, a request for telephone repair, a trip to the hospital, or the purchase of groceries.

The services and influence of the Charlotte Council on Alcoholism, as the effect of its present and past performance is reviewed, represents all this and more to this community.

Can we properly call alcoholism a community responsibility? Can it properly be called anything else? Let's take a look at the vast complex of social confusion surrounding the use of alcoholic beverages and its effects and see just what sort of pattern results.

(Continued on page 14)

Seasons Greetings

IT'S that "special" time of year again
Of peace on earth, good will toward men
Of hearts aglow and mistletoe
And stockings hung all in a row.

Of colored lights and tinsel bright
Of carols echoing through the night
Of decorations green and gold
And presents stacked four a'fold.

Of laughs of glee and shopping sprees
Of spicy aromas and goodies to please
Of forbidden closets and special places
And smiles adorning cherubic faces.

And now that Christmas time is here
And Santa's visit draws ever near
We wish to every one of you
A blessed Christmas and New Year, too!

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The Jonah Syndrome

A psychiatrist and minister uses a Biblical analogy to illustrate a particular syndrome experienced by Jonah and many alcoholics.

BY NORMAN A. DESROSIERS, M.D.
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ALCOHOLIC REHABILITATION CENTER
BUTNER, N. C.

This address, published by permission of the author, was delivered at the spring meeting of the Alcoholism Programs of North Carolina in New Bern last May 10.

MAETERLINCK, in one of his wonderful stories of the Middle Ages, tells about a very powerful man who had to work terribly hard all his life and who was always striving, it seemed, against tremendous odds to reach just a few of the triumphs attained by brilliant men and women. One day he discovered that surely there must be a man somewhere who was his enemy and who followed him about undoing everything good that he could possibly do. One evening as he was walking down a path, he saw a man coming in the opposite direction. He knew, by that instinct which tells us unconsciously that there is danger afoot, that this was his mortal enemy. As he approached the man, he saw that he was masked and said to him, "It is you who has always been trailing me throughout my life upsetting every good effort that I have ever made. I have had to work hard to overcome what you have undone. I propose to kill you, sir. Draw your sword and defend yourself." The man looked back at him and said reluctantly with a voice remarkably similar to his own, "Before you attack me, sir, allow me to show you whom you are about to kill." When he took off his mask, the man stood before himself!

I tell this story because when an individual becomes entrapped in the vicious cycle of the illness of alcoholism, he is truly his own worst enemy, as Maeterlinck's story illustrates in crystal clear terms.

It has often been said that the use of alcohol produces depression and because of this I propose to discuss a particular syndrome that can best be illustrated by a Biblical analogy. As a matter of fact, it is called the Jonah Syndrome because elements of the story of Jonah, and the clinical expressions of it, keep popping up again and again among those individuals who come to the Center in a sober state. Jonah's feelings, as I will reveal them to you presently, parallel closely those of many of our patients.

Jonah, as you will remember, was one of the lesser prophets and was

called by the Lord to go to the city of Nineveh to preach against it that it should repent of its evil. Well, Jonah loved his own people, feared his Lord, but he did not like the Ninevites one bit. So what did he do? He sneaked off. He booked passage on a ship going to Greece. And in order to be sure that nobody saw him, he sneaked down into the hold of the ship after he had paid passage and promptly went to sleep. While Jonah was sleeping, a terrible storm arose. Everybody began throwing stuff overboard right and left in order to lighten the ship—everybody, that is, but Jonah who was spotted sound asleep and raked over the coals: "Look here, you are sleeping while everyone else is working throwing stuff overboard. Who are you anyhow? Where are you from? What is your land? Where are you going and why are you going there?"

Jonah's Confession

Jonah, struck to the core and realizing, according to his way of thinking, that it was his fault that the natural elements had descended upon them, confessed openly and said, "Look, the Lord has raised up this storm because He is angry with me and is demanding my life. Therefore, if you want to calm the sea, throw me into the waters and the storm will be ceased." The ship's crew didn't want to do this and they rowed like mad, but they couldn't get to shore. So they finally tossed Jonah into the brink where, according to the story, the Lord was prepared for him and he was swallowed by the whale and stayed there for three days.

At this place of hitting bottom, so to speak, Jonah prayed in desperation to the Lord, saying that he had gone as low as he could and would the Lord please deliver him. It is a beautiful prayer, closely paralleling one of the psalms. As the story goes, Jonah was spewed out or, as the King James version puts it, vomited out upon dry soil and again the Lord said to Jonah, "Go and preach to the Ninevites."

This time Jonah was so scared that he didn't dare back out, but he went reluctantly. It took him three days to walk across the city which was full of people and cattle. Jonah didn't believe that the Ninevites would repent and as he preached he was so angry that he hoped the Lord would slay them. (To get rid of them was, of course, his secret desire.) However, it just so happened that the King of Nineveh was a righteous man and he did repent. He issued an order that the people should repent and the whole city did. It is said that the Lord repented of his design against these people and saved the city of Nineveh.

Jonah, however, didn't believe it. He didn't believe it at all. He went upon a hill outside the city fully expecting the Lord to level it with an earthquake as he had Sodom and Gomorrah in earlier days. While he was up there the Lord asked him, "What are you so mad about, Jonah? Will you do well to be so angry?" But Jonah was so mad he wouldn't even answer the Lord. While he was sitting upon the hill outside the city exposed to the elements, with the hot east wind blowing, drying out everything, the Lord caused a gourd to grow which produced shade and Jonah was a little happier. But, during the night, in order to teach him a lesson, the Lord sent a cold wave and the gourd collapsed. Jonah then made a very characteristic remark, which he repeated three times, that constitutes that which I wish to talk about now—the Jonah Syndrome. He said, "Oh Lord, I am so angry, take my life from me."

Now if you will go back over the

story closely you may discover that Jonah had a number of characteristics in common with one particularly large group of individuals who are addicted to alcohol. One is the tendency to withdraw from the responsibilities life places upon them. You remember that Jonah was a man of prophecy. This was his work. As a prophet he was called to proclaim the Word of the Lord against all social unrighteousness. This was his calling, and he attempted, like so many people who have the particular problem of alcoholism do, to withdraw from the situation by changing his geographical location. But he didn't get away with it because he could not get away from himself.

A Sensitive Conscience

Because Jonah could not get away from himself, and I'm not moralizing now, I'm just using the Biblical illustration because I think it is valid, he immediately exhibited in the face of adversity one constant characteristic that is always involved in the Jonah Syndrome—a sensitive conscience. For some reason, people who are addicted to alcohol have found that they have very sensitive consciences and are almost willing to pay the price—almost, but not quite. When Jonah ran into the adversity of the storm and was confronted with what he had done by those about him, he readily admitted his guilt and was almost, but not quite, willing to take the consequences. He pleaded for a second chance, which should strike a responsive chord with those of you who work with alcoholics.

Because the Lord is merciful and just, Jonah was given a second chance and he took it. He went to preach to the Ninevites, but he had not really resolved his feelings about the matter. He both feared and loved the Lord, and in this case the fear of the Lord and the love of the Lord are synonymous, but he was also terribly angry with Him. Jonah had tremendous courage. It is not easy to be angry with God, but Jonah was and he told him so right to His face. I would not have had the courage to do it, but Jonah did. You have to give him credit for courage. Jonah was honest. He was angry with God for not destroying the Ninevites. He was attempting to manipulate God into carrying out his own destructive wishes, and he was twice as angry with Him for taking away the gourd which gave him some protection from the sun. And yet, at one and the same time, he prayed to Him for deliverance. Now if this isn't a classic definition of the third thing I want to bring out—ambivalence—I don't know what is.

Last, but not least, I want to come back to the real definition of the Jonah Syndrome. You will note that there wasn't a thing Jonah could do about the situation. Despite all his verbal expression, he just couldn't get back at the Lord because the Lord was not available to receive his blow. What, then, was he going to do with the particular morbid emotion residing in his breast?

Let's consider what Jonah did do: "Oh, Lord, I am so angry, let me die." And, of course, this is the psychodynamic that exists behind all depression—anger which cannot find expression appropriately or constructively and gets turned upon itself. The formula is repressed hostility.

Yes, the Jonah Syndrome consists of the classical signs of depression, a commonly missed diagnosis. Depressed persons are withdrawn and exhibit loss of interest in the usual activities of church, family and friends. A super-sensitive conscience is always involved because there can be no depression without guilt and self-reproach. Loss of interest, loss

of appetite, loss of sleep, anger—all come out under the facilitating influence of alcohol upon the frontal lobes of the brain. Tremendous ambivalent feelings are evidenced, for instance, by the patient in D.T.'s who curses you up a blue streak one minute and hugs your neck the next.

I am not dogmatically saying that alcoholism and depression are synonymous, but I think they may be causally closely related. And, of course, depression is not the sole thing that we see in our patients—it is just one thing I have chosen to talk about. There are many other causations, sociological, psychological and physical, as well, and there are all degrees from very mild to very severe all along the way. Just remember, however, when you come across the Jonah Syndrome, that the goal of depression is death—either by the rapid route or the slow route. The depressed individual does not eat well, sleep well and loses interest in his surroundings. He is a very angry person—with himself. He is truly his own worst enemy.

I'm emphasizing these things so that you may be of help to the persons in whom you see these signs. They need that constant, close and warm interpersonal relationship which you alone are so capable of giving them because you are there where they are. It is true that in order to help an individual in any distress you have to be able to accept him as a human being in your own feelings with guilelessness properly motivated, despite whether he is addicted to alcohol or anything else. But this is only acceptance. It takes so much more, as you well know. However, one of the main therapeutic instruments that anybody can give to anyone who has ever had any difficulty of any sort, whether it be emotional, spiritual, physical or mental, is a kind of non-hurting, genuinely loving—and I use the word love in the broad sense of brotherly love—relationship. This is the main therapeutic instrument, but it must be more than guileless. It must incorporate a non-judgmental, informed, intelligent and understanding approach.

There are many degrees of alcoholism, as I have indicated, and I am in the treatment business because I consider all of them serious. There are evidences in the social histories we get, for example, that the use of alcohol, from the first drink in a special interpersonal situation at a high school dance, is pathological from the word "go" and remains so from then on. They all begin somewhere. When they get out of high school and face a job, there is a little increase. They choose a life's mate and there's another little increase. The problems of children come along which demand more adjustments and there is more increase.

Serious Illness

I consider alcoholism a very serious illness both psychologically, one facet of which we have discussed, and physically, because of the chronic progressive deterioration of one of the most important systems in the body, the nervous system.

I hope I have raised a few serious questions in your mind about some of our thinking along this line and I'm certain we are always thinking and re-thinking our approach to this problem. It is going to take some hard work and sacrifice on your part and mine because the job that is before us is an immense one. Thank God some of you have taken constructive and definitive action out of genuine concern for your fellow man to the degree that you are concerned enough to give some of your time to fighting one of our worst major illnesses.

Treatment of the sober alcoholic for his alcoholism is a real challenge to the patient, his family, minister and physician, and society.

CLERGYMEN have been helping troubled people for thousands of years. They have helped countless generations of human beings with their emotional problems, an endeavor to which psychiatrists are fairly new. Personally, I have great respect for religious leaders. I believe they have an exceptional opportunity to help troubled people. You have, by nature of your office, a well-established relationship with your parishioners which in itself eliminates some of the difficulty we psychiatrists have in dealing with people.

The treatment and rehabilitation of alcoholics may be divided into three phases: Treatment of the acutely intoxicated alcoholic; treatment of the alcoholic in the withdrawal period; and treatment of the sober alcoholic for his "alcoholism" as a disease process.

The treatment of the alcoholic in the first two phases is largely a medical problem, familiar to almost every physician. Here I would like to mention that these phases can best be treated in a general hospital. I should like to emphasize this because you as ministers and leaders

A Psychiatrist Talks with Clergymen

By Mehdi L. Yeganeh, M.D.

Used by permission of the author, this article was taken from a paper addressed to an Institute for Clergy. Dr. Mehdi L. Yeganeh is the psychiatrist in charge of Spring Grove State Hospital's Alcohol Unit, Catonsville, Maryland.

in your community can influence the thinking and attitudes of people. It is unfortunate that some general hospitals, because of misunderstandings, and probably some prejudice, are reluctant to accept the intoxicated alcoholic or to treat him during the withdrawal period, although his symptoms during these phases are medical problems comparable to those of any other illness. The general hospital has laboratory facilities and emergency provisions such as intravenous infusions and various medications. Without its help the family often does not know where to turn. Hospitalization removes the patient from his environment and may break the vicious circle in which he has been caught. It can be a turning point in his life.

One of the reasons for the reluctance of the general hospital to treat alcoholics is the difficulty they have encountered with these patients in the past—but that *was* the *past*. Nowadays hospitals have adequate tools, very effective medication, and all the facilities to take care of these people. I do not believe the alcoholic in a general hospital is any more of a management problem than any other patient. To quote from Dr. Marvin Block, chairman of the Committee on Alcoholism of the American Medical Association: "There is no substitute for general hospitals in caring for these patients and anyone with experience in treating the alcoholic will agree that there is very little difficulty with most of them. Records in hospitals where these patients have been treated report no more difficulty than with any sick person."

The third phase, namely, the treatment of the sober alcoholic for his alcoholism, is a rather difficult and complex problem—a real challenge to the patient, his family, his minister, his physician, and society. As you know, these people are still sick. They are only "a drink away from being drunk." Some may be able to control their drinking for a few days, or a few weeks, but it has been our experience that sooner or later they will lose control and run into the same old trouble. We believe the first step in treatment and rehabilitation of the alcoholic is his acceptance that he *is* an alcoholic and his acceptance that he cannot drink any more. There are reports in professional literature of a few cases of confirmed alcoholics who have received intensive psychotherapy and have been able thereafter to drink socially, but this outcome is quite rare and an exception to the rule. Therefore, we prefer to stick to the policy which has proved sound for the vast majority, namely, requiring the patient to stay away from alcohol and to maintain absolute abstinence. This is, of course, more easily said than done, and alcoholics are aware of the difficulty. They know they cannot control their drinking, having learned from experience, but they keep hoping they will be able to do so. They hope one day to be able to drink socially. In fact, they sometimes go to the doctor to learn how to drink, rather than how to stay sober.

When the patient has accepted the fact that he is an alcoholic and that he cannot drink any more, the next requirement is motivation, a sincere desire to remain sober and to adjust to life soberly. This is very important because the alcoholic has a difficult task before him. He has adjusted to life for many years with the help of alcohol. He has used alcohol as a tranquilizer, an anti-depressant, a social lubricant and generally speaking, a crutch in his inter-personal relationships. Because he has been using such a crutch, he never has learned to use his own "legs."

Now we are taking away this crutch and are expecting him to adjust to life on his own "two legs" which are naturally weak from disuse. Under the circumstances, he must be highly motivated to learn to rely on his own legs and not resort to the crutch so easily available to him.

This is the time when ministers, physicians, social workers, psychologists, employers, families, and Alcoholics Anonymous members can come to the patient's aid. Which can be most helpful is very difficult to say. I have seen many alcoholics helped by their ministers, many by A.A., some by psychiatrists, social workers, or others around them. Some have needed and used the help of many resources.

Generally speaking, alcoholism is considered to be a medical and a psychiatric problem. In the nomenclature of the American Medical Association it is classified under psychiatric disorders, but I must admit that psychiatrists have not been very successful in helping alcoholics. There are many reasons for their lack of success.

One Major Problem

One of the major problems in psychiatric treatment is the alcoholic's ambivalent feelings toward alcohol. On the one hand many years of experience have shown him that alcohol can be helpful to him, but on the other hand he has found it extremely harmful, interfering with his livelihood and so on. He has positive and negative feelings about it. Whenever he feels frustrated, whenever he become anxious, whenever he feels depressed, it is the first thing which comes to his mind. In working with psychiatrists in treatment a patient necessarily goes through periods of frustration, anxiety, depression and so on. Ordinarily, non-alcoholic patients can tolerate these stresses until they work them out, but the alcoholic usually turns to drinking and consequently interferes with the progress of his treatment.

I mentioned that we psychiatrists have not been very successful in treating the alcoholic, but we have not given up. At least some of us are still in this field, still trying to do something to help the alcoholic. There are several ways in which we can be helpful to the alcoholic. Besides treating alcoholics in acute intoxication and withdrawal periods, which is, as I noted above, a medical problem, the psychiatrist can be helpful in treating the sober alcoholic for his alcoholism. We can divide such help into two levels: the global level, and the personal level.

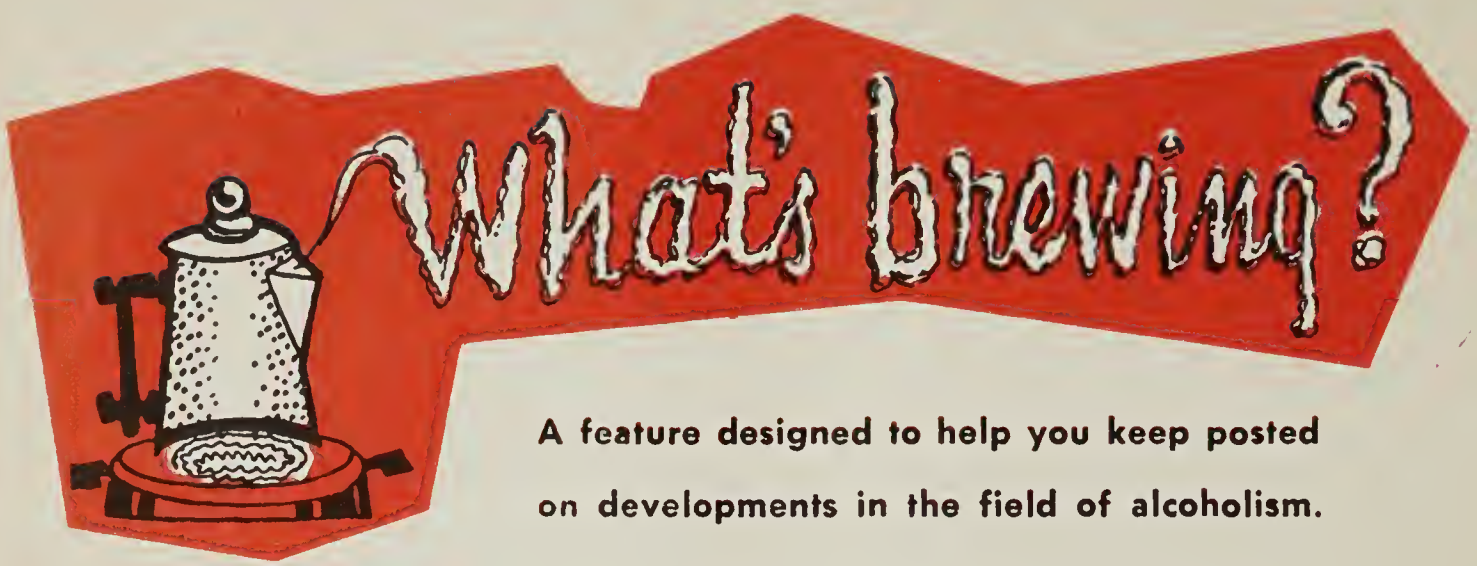
At the global level the psychiatrist can be helpful as a part of a therapeutic team in what is referred to as a multiple-disciplinary approach. Such teams operate in many different setups, for example, outpatient clinics, daycare centers, state hospital units, voluntary inpatient facilities, and so on. In all such programs the psychiatrist can function as leader of the therapeutic team or as a part of the therapeutic team.

Group therapy has been found helpful for the alcoholic. In fact, some alcoholics seem to do better in group therapy than in personal psychotherapy. There are some conventional therapeutic groups, and some modified groups or meetings which tend to be mostly didactic and inspirational.

At the personal level, a large majority of alcoholics are not good candidates for intensive psychotherapy or psychoanalysis. However, they may benefit by a less intensive, more supportive kind of psychotherapy.

We now have effective drugs, quite safe and non-habit forming, which

(Continued on page 19)



A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: William P. Kemp, Sr. of Goldsboro has been named to succeed John W. Umstead of Chapel Hill as chairman of the N. C. Board of Mental Health. Though Mr. Umstead retired recently, he will remain a lifetime member of the Board under an act passed by the General Assembly. Mr. Kemp has served on the Board for several years and moves up from the vice chairmanship. Frank Umstead of Chapel Hill will take his father's seat on the Board.

NEW BERN, N. C.: Approximately 200 persons gathered at the Shrine Club in New Bern on October 12 for the annual banquet of Alcoholics Anonymous groups in New Bern and Craven County. Guest speaker for the occasion was Manuel B. of Columbia, S. C. The following morning, a brunch was held at the Palace Motel. The sixty-five persons present from all sections of North Carolina and from South Carolina, Virginia, and Washington, D. C. heard Pete F. of Norfolk, Virginia.

BURLINGTON, N. C.: A new alcoholism program has recently been organized in Burlington. The Alamance County Council on Alcoholism has offices at room 802 in the N. C. National Bank building. Mrs. Margaret Brothers, formerly with the Greensboro Council on Alcoholism, is serving as executive director of the new council.

STRAFFORD, PA.: The 17th anniversary citation dinner of the Malvern Institute for Psychiatric and Alcoholic Studies was held on October 24 in Strafford. Dr. Ruth Fox, Medical Director of the National Council on Alcoholism, was the guest of honor and ninth recipient of the Institute's Citation of Merit.

Dr. R. Gordon Bell, medical director of the Bell Clinic of Willowdale, Ontario, Canada, was guest speaker for the occasion and spoke on the relationship of stress to alcoholism. Dr. Bell said that there are 80 new drugs on the market known as tranquilizers from which 600 brands are being manufactured. Many, he said, if improperly used, can be far more dangerous than alcohol. The danger lies in using these tranquilizers too often, too much or too long. Dr. Bell said that alcoholics must transfer their dependence on alcohol and tranquilizing drugs to other things such as group or occupational therapy.

CHAPEL HILL, N. C.: NCARP associate director Dr. Norbert L. Kelly was the guest speaker at a meeting of the North Carolina Association of Health Educators in Chapel Hill on November 22. Dr. Kelly spoke on the "Organization of the Educational Division of the North Carolina Department of Mental Health."

WASHINGTON, D. C.: In order to clarify the functions of the three major alcoholism organizations in the United States, a joint Statement of Purpose leaflet is being prepared by the National Council on Alcoholism, Alcoholics Anonymous and the NAAAP. The pamphlet will be used to guide information seekers to the proper organization and to outline, in capsule form, their different areas of interest.

ATLANTA, GEORGIA: State mental health leaders from 16 Southern states met in Atlanta recently to discuss services for the mentally ill following their release from state mental hospitals. The conference was sponsored by the Southern Regional Education Board.

For six consecutive years the population of mental hospitals in the South has decreased although admissions have increased. In 1961, 49,351 patients were discharged to the community from 57 state mental hospitals in the 16 Southern states participating in the Southern Regional Education Board's health training and research program.

Results of the conference in Atlanta will be used by the Southern states in their planning and program development and for future experimentation and demonstration in improving aftercare provisions.

DURHAM, N. C.: The Alcoholism Programs of North Carolina elected officers to serve for a two-year term at the annual fall meeting in Durham November 8. Worth Williams, executive director of the Greensboro Council on Alcoholism, was named president to succeed Marshall Abee, executive director of the Alcoholism Program of Forsyth County. Other new officers of the organization are Don Dancy, executive director of the Asheville alcoholism program, vice president; Mrs. Olga Davis, executive director of the Durham Council on Alcoholism, secretary; and Joe Pinkston, supervisor of alcoholic rehabilitation in the N. C. Prison Department, member-at-large.

CHAPEL HILL, N. C.: A University of North Carolina experimental psychologist is currently engaged in research that may have a bearing on how mental patients behave while under the influence of certain drugs. In experiments conducted with rats and pigeons, Dr. Marcus B. Waller, assistant professor in the UNC Psychology Department, has administered two drugs which are used in the treatment of mental patients—chlorpromazine and phenobarbital. The results of his studies may have bearing on the behavior of mental patients who receive the same two drugs.

ASHEVILLE, N. C.: Persons attending the Southern Regional Conferences on Mental Health Statistics in Asheville recently were told that the number of mentally ill patients now under custodial care could be cut in half in the next 20 years. But Dr. Morton Kramer, chief of the Biometrics Branch of the National Institute of Health in Washington, D. C., said that this could be accomplished only if the states and their mental health programs concentrated their efforts in a number of ways.

Dr. Kramer said that more comprehensive community mental health centers would have to be established—together with the inclusion of inpatient, outpatient, preventive, therapeutic, and rehabilitative services. There would have to be additional psychiatric services provided by general hospitals as well as adequate inpatient and outpatient facilities and programs for the care of seriously emotionally disturbed children and adolescents. In addition, satisfactory facilities for placement of chronic and aged psychotics and nursing homes and other facilities for patients suffering from mental disorders associated with old age would be needed.

COMMUNITY RESPONSIBILITY

CONTINUED FROM PAGE 4

The experimental drinker, the heavy social drinker, the problem drinker and even the unconvinced alcoholic might say, "My drinking is nobody's business but my own. Nobody is going to tell me what to do." Many people in the community say, "This is a problem for the law." Others pass the responsibility to the church and the medical profession. "Talk with your preacher," says one. "Go see your doctor," says another. And both in exasperation and desperation urge "AA is the only answer." The welfare department comes in where indigence, disability or child neglect is the presenting need. Distraught families may use state or private hospital commitment. Mother Army gets a goodly representation as any induction center can attest. The soup kitchen, skid row, various retreats and drying out resorts of mean or exotic description serve as the answer for countless thousands.

Meanwhile, the municipal courts lubricate the revolving door. The Salvation Army furnishes a meal and a night's rest. County jails, workhouses and prison camps stock extra supplies for the Thanksgiving and Christmas increase in census. Fraternities laugh at, endure, ignore and finally suspend or expel their inevitably insecure problem drinkers. Social clubs, civic clubs, professional and trade organizations appoint entertainment committees, assess the membership for "refreshments", designate room "X" as the social center, and then accept with more or less resignation the fact that "so-and-so" will probably have to be watched, warned and then put to bed.

Clergymen are unfrocked; deans are dismissed or given the opportunity to "resign with dignity;" skilled workers are excused, protected, probated, suspended and then fired. Patients are admitted to hospitals with misleading d i a g n o s e s. Insurance forms are filled out with an eye more to collection than to honest evaluation. Industry's "billion dollar headache" grows more frightening while absenteeism increases. The stability of the home is shaken and delinquency rises. The problems of voluntary agencies increase with the loss of self-reliance of the individual and the increase of social decay is evident.

Alcoholism and we who are blind to its significance as a community responsibility might be likened to the story of the elephant and the five blind men, who, when asked to explore its mammoth mystery, came up with impressions that it was a rope, a fan, a tree, a wall and a snake—with arguments and convictions to match.

Although the main purpose of this discussion is to remind you that alcoholism is a total community responsibility, I would prefer to leave with you also the challenge that you review searchingly, and with practical concern, a few simple and basic behavior patterns that are found in most of us which make more difficult the application of our resources of help for the alcoholic, and which delay his being brought face to face with the urgency of his own need:

1. How prone we are to ignore or forget (or defy) commonplace warnings or restraints—"Watch Your Step", "Dangerous Curve—Go Slow", "Speed Limit 60 Miles Per Hour", "H i g h Voltage", "Poison—K e e p Away From Children", "Remove Door of Abandoned Refrigerator", "Slippery When Wet." Just so, we ignore, forget, flaunt or defy the early signs of problem drinking and alcoholism.

2. Statistics of death and disaster are read and laid quickly away in that closet of the mind that is reserved for the unpleasant and threatening, and its door is closed with the child-like philosophy of omnipotence, "It can't happen to me."

3. The lesson of the example of the Good Samaritan meets its match with the oft-asserted twentieth century independence of "Mind your own business" or "You tend to your knitting and I'll tend to mine." In much the same way neighborly concern is made obsolete by the old English assertion that "A man's home is his castle."

4. Our rigid childhood code, "Don't be a tattle-tale", finds an adult hatred of the informer, contempt for the stoolpigeon, and a pretty sour regard for the tax investigator who is just doing his job while he, in turn, has questionable regard for the tax informer. Yet, a thin line may be all that separates these attributes or conditioning from the impact of testimony in court, data for a social service interview, or confidential reports and certifications sought by federal or other official agencies regarding our appraisal of the loyalty or potential of someone known to us.

I cannot adopt nor set limits for you concerning how these patterns or attributes might apply in the area of your consciousness of community responsibility, regardless of which specific interest draws your concern. But in the total complex of all agencies and services that feel directly or indirectly the effects upon the community that stem from excessive drinking, problem drinking or alcoholism, a perceptive self-appraisal might bring about some change in how each of you sees yourself as a responsive and responsible member of the community in which you live.

You and I alike must set the borders that separate meddling from justified concern. How much of our community activity is curiosity, self-satisfaction, escape from our own problems in absorption with problems of others; or how much of it is mature contribution that comes with genuine, unselfish concern for the individual and his place in the community, with realistic and appropriate action to match?

The alcoholic defies understanding —he cannot even understand himself. He resists help that is proffered with the tag, "It's for your own good", and he cannot help himself. He fits no personality norm, and he is found among all types. There is only one common denominator—he cannot control his drinking and he resists most efforts to have it controlled for him with remarkable ingenuity and tactic. The deterioration, the devastation he wreaks upon himself, his family, his intimates, his job, and his community defy adequate description or appraisal. His positive and active course in this behavior illness is considerable and well-known to all. The negative role is less appreciated to the extent he falls short of his potential or fails totally in community contribution.

Alcoholism, in all its manifestations, is the personal concern of every community. It is a community responsibility of the highest order. There is no simple solution. There is no stereotyped pattern of management. There is no cure for the individual who is so addicted. There are, however, avenues of approach that broaden the horizons of understanding. There are means of sensible and sensitive action. There is the goal of understanding for those who would work with this problem, and the goal of attaining or achieving sobriety for the alcoholic. Only in the setting of total community effort can adequate results be achieved with the numbers involved.

The efforts of the alcoholic

need to be consistently fostered

POSITIVE STAFF AT
TREATMENT OF T

BY RONAL

SPECIAL CONSULTANT O
FIRLAND
SEATTLE

ALCOHOLISM means many things to many people. When I say people, I am speaking about the members of our total community—about alcoholic patients, about agency people and, most importantly for our purposes here, about the people who play treatment roles in our hospital structure and in follow-up after hospitalization. The present attitudes of our community toward the alcoholic patient have wide implications and must be improved if we are to fulfill our treatment responsibilities.

Before exploring the effects of community attitudes on alcoholism treatment, let me first state what I mean when I speak of alcoholism. I believe this is necessary because there are almost as many ways of defining alcoholism as there are attitudes toward it.

Alcoholism is a term used to identify a disease process which begins with using alcohol to adjust to the trials and tribulations of everyday living. Let me emphasize from the outset, however, that not *everyone* who drinks excessively is an alcoholic. Alcoholism is defined not by how much a person drinks, but by how alcoholic beverages affect the drinker. The effect is the determining factor in this disease. One way of evaluating the effects is to look at what has happened in the drinker's social adaptations. Does alcohol cause a continuing problem in his work, his family life, his social relationships and/or his physical health? If so, then clearly, he has a problem with alcohol and he can be called a problem drinker. Alcoholism can be diagnosed when compulsion sets in after the first drink or two and certain symptoms with predictable patterns inevitably follow.

I may seem to have spent an undue amount of time saying what I mean by alcoholism when I was asked here to discuss program planning. I have done so purposely because I believe that the essential first step in program planning is for the planners to reach an agreement about what they mean by alcoholism, otherwise communications are needlessly obscured.

What has all this to do with tuberculosis? It is my opinion that more and more time will have to be spent in conferences such as this in the future because larger and larger proportions of our tuberculous patients will have the hyphenated diagnosis of alcoholism-tuberculosis. Excessive alcohol use, by its very nature, indicates a poor system for life adjustments and is not conducive to good health practices in maintaining or building bodily resistance to disease. Therefore, it is our responsibility as members of treatment teams to work through all the prob-

erculous patient toward recovery

y all staff members at all times.

ITUDES—THE KEY TO THE SUCCESSFUL E ALCOHOLIC TUBERCULOUS PATIENT

. FAGAN, B.A.
IEDICAL-SOCIAL PROBLEMS
ANATORIUM
ASHINGTON

This article is based on a paper presented by the author at the 11th annual meeting of the Western Tuberculosis Conference which met September 11-13, 1963 at Portland, Oregon.

lems in the diagnosis, treatment and management of alcoholism-tuberculosis so as to help patients to return and to remain in the community with as fully restored health as possible.

If there is any one practical necessity before a program of effective treatment of alcoholism-tuberculosis can be built, it is to change the community's attitudes toward alcoholism from predominantly negative and pessimistic to realistic, matter-of-fact acceptance. Our patients come from our community. So does our staff. The attitudes of our community toward alcoholism are the attitudes of our hospital. For example, if the alcoholic patient accepts the community's evaluation of his illness and of himself, his low self-esteem will handicap him in forming therapeutic relationships and his low hope for recovery will make entrance into a treatment program seem useless. If his non-alcoholic roommate is contemptuous of him, remaining in treatment becomes less likely. If the medical staff have no understanding of his illness, they cannot be expected to treat his disease realistically.

Many of the patients found in tuberculosis hospitals today who have personality problems and with whom the staff have difficulties, initiated their treatment in clinics of community agencies, county and city hospitals, and jails. It is quite apparent that these patients have experienced the full range of community attitudes and are conditioned to expect continued lack of knowledge and understanding of their disease or of their "alcoholic way of life" and its bases. This conditioning has led to a "digging in of the heels" and it is small wonder that we find a reduced rate of patient-cooperation with staff and a low rate of recovery among these patients.

It is totally unrealistic as planners to view the sanatorium as an island in which desirable attitudes toward

alcoholics and the treatment of alcoholism can be engendered and maintained apart from the community. The sanatorium *is* a part of the community. Unless we coordinate our efforts with community efforts to change attitudes and to develop effective treatment, our plans will be difficult to implement. The problem of alcoholism treatment in tuberculosis hospitals is not simple. Again, we must reach out and enjoin our efforts with those of the total community.

Another error we make as planners is in talking about alcoholism-treatment programs. We imply that all alcoholism is the same, that all alcoholic patients are alike. This simply is *not* the case. There are different types of alcoholism. Also, each alcoholic is different. The patient is a great deal more than his disease. This is a truism when any illness but alcoholism is being discussed, but here is a point which must be stressed. Each alcoholic patient is a physiologic, cultural and psychologic entity, identical to no other human being. The interplay of these elements bears on how he became ill, what his illness and hospitalization mean to him, and the use he can make of help in recovering.

By speaking of alcoholism-treatment programs as if all alcoholism is the same, we also interfere with our own abilities to plan effectively. We lose sight of the necessity for programming many forms of treatment for tuberculous alcoholics. A multidisciplinary approach is necessary. Some patients will require individual psychotherapy; some will need group therapy; some will respond to antabuse therapy; some to Alcoholics Anonymous; others to a persistent understanding relationship with a fellow patient or a staff member. Some will need all of these; others will never recover.

Another common error made by planners is to assume that an alcoholism-tuberculosis treatment program can be built effectively by hiring alcoholism "experts." The fallacy here is that the patient is not two separable halves, one of which is alcoholic and one tuberculous. And we cannot conveniently assign these non-existent halves to separate professionals who treat in isolation from one another.

Alcoholism-tuberculosis, like diabetes-tuberculosis, requires unified treatment; that is, treatment of the whole person and all his pathology by one physician.

I can hear the medical people among you saying, "But isn't the treatment of alcoholism highly complex? I haven't been trained for this. I'm not a psychiatrist." The literature on the treatment of alcoholism, with or without the complications of other illnesses, indicates clearly that no one medical specialist has been more successful in the treatment of alcoholism than any other. The common characteristic of those who treat alcoholism successfully is not a particular specialized training but, rather, the ability to relate to, accept, and understand the patient and his chronic illness.

In April of 1962, Firland Sanatorium enlisted the aid of four leaders in the treatment of alcoholism and tuberculosis to help us develop our programming. Two major themes came out of this five-day conference; (1) It is of prime importance that a staff member establish a warm, accepting relationship with the alcoholic tuberculous patient early in the hospital course; and (2) that tuberculosis-alcoholism treatment is a case of people working with people—that it is on this human dimension that successful treatment will be built.

Another way of restating this sec-

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have been fairly successful in the treatment of alcoholics. In our Spring Grove program we make extensive use of tranquilizing medications, antidepressive medications, and some other drugs like antabuse. These drugs have the capacity to decrease the patient's anxiety and improve his mood, but are not used as a substitute for alcohol. Most alcoholics resume drinking because they feel anxious, nervous, restless, sleepless or depressed. If we can alleviate these symptoms with medication, we have a better chance of helping the alcoholic to stay away from drinking long enough to make a better adjustment to life.

There are some other specialized methods of treatment such as aversion treatment, hypno-therapy, and new drugs like LSD, but I shall not go into details regarding them here.

In general, we may all help the alcoholic by remembering and directing our efforts on the basis of the following:

1. Help the alcoholic to accept the diagnosis. As in any other medical condition, the patient himself must accept the diagnosis. He has to admit that he is an alcoholic so that he can accept treatment. In other medical conditions usually the patient does not have much difficulty in accepting a diagnosis, but in the case of alcoholism the patient usually is the last one to accept the fact. Often his relatives, his friends, his employer, and his physician have been aware of it for a long time.

2. Help the alcoholic to learn to adjust to life without alcohol. Any amount of alcohol of any kind can trigger the patient into another binge and another vicious circle.

3. The old way of blaming the alcoholic, threatening him, and so on does not work. It may, indeed, increase his anxiety or his depression and push him further toward drinking.

4. It is very important not to confuse our own feelings and needs with the patient's needs and feelings. For example, if we have a need to lecture, we should not capture him as a listener. I mention this because alcoholics are a good captive audience. They listen, nod their heads, but don't hear what is said.

5. It is important to know that alcohol means a lot to the alcoholic. He has positive as well as negative feelings toward it.

6. Alcoholics tend to be dependent people. Sometimes we may let them be dependent on us but in general we need to encourage them to grow on their own.

7. Some alcoholics are manipulative individuals. If we permit ourselves to be manipulated by the alcoholic, we are likely to get angry with him, and this naturally interferes with his treatment. It is very important to develop resistance to alcoholics' manipulations if we expect to continue working with them.

8. Not only are alcoholics ambivalent toward alcohol, but their families often have the same kind of ambivalence. Often the alcoholic's wife, for example, is the daughter of an alcoholic. She has had some unconscious motivation to marry an alcoholic and a good deal of her relationship with her alcoholic husband has some unconscious neurotic motivation.

9. Often the alcoholic and his family are caught in a vicious circle. Sometimes a little bit of help from a minister or from a psychiatrist, physician, A.A. member, marriage counsellor, or some understanding person can mean enough to the alcoholic that he can break out of that vicious circle.

ALCOHOLISM and PUBLIC HEALTH

BY E. HOLT BABBITT

DIRECTOR, ALCOHOLISM PROGRAM
MANSFIELD-RICHLAND COUNTY HEALTH DEPARTMENT
MANSFIELD, OHIO

PERHAPS you have heard the statements, "Alcoholism is a public health problem" and "Alcoholism is the third major health problem in the United States." What is the meaning behind these broad and all-encompassing statements?

Alcoholism education and treatment have received considerable emphasis in the United States since the founding of Alcoholics Anonymous in 1935 and the Yale Center of Alcohol Studies (now Rutgers Center of Alcohol Studies) in the early 1940's. Concurrent with the rapid growth of government and voluntary alcoholism programs, the above statements have also received their share of publicity. The latter quote sometimes uses the numeral "4" rather than "3", depending on the source of information. But let's not quibble over the rank order of the illness. Mention in the top five health problems certainly implies the seriousness of the illness of alcoholism.

Granted that alcoholism is a public health problem as well as an individual health problem, why has not this illness gained wider acceptance throughout the country in the many health departments? Public health means the well-being and continued healthy existence of society. Receiving important emphasis are early recognition and prevention of disease and elimination of unsuitable living conditions. The major divisions are environmental sanitation, communicable and chronic disease control, health education, vital statistics and child health.

Also by definition, public health represents the organized effort on the part of society to protect and preserve the health of large numbers of people that cannot be accomplished through private efforts alone. This in part explains why health departments have not uniformly adopted alcoholism in the family of public health problems. Other reasons are discussed in following paragraphs.

Public health is something in our society which is taken for granted. We expect and demand to live in a healthy environment free of epidemics, disease and squalor. But yet, it is an area which must fight for operating monies. Progress is not

measured in dollars and cents; it is gauged by healthy, disease-free infants, children and adults. The community benefits of an effective public health program are not as discernible as efforts directed toward better freeways, shopping plazas, parks, and recreation areas.

The bulk of public health efforts in years past has been the continuous fight to eradicate and control communicable or infectious diseases. Polio, tuberculosis, venereal disease, diphtheria and other diseases have one by one been brought under control. Mansfield, Ohio and surrounding Richland County have enjoyed five polio-free years. Were it not for the Salk vaccine and more recently the Sabin Oral Polio Program for immunization, such a record would not be possible. Over 70,000 public-health-minded individuals turned out in the summer of 1962 to receive the oral vaccine.

As society records rapid changes in all phases of living, public health is also readjusting to meet contemporary needs and problems. Health situations receiving current attention are accident prevention, fluoridation, air pollution, radiation hazards, chronic disease control, vending machine regulations, mental health and alcoholism.

In some ways, alcoholism is similar to other health problems, but in other respects, there are considerable differences. The greatest progress in preventing diseases has been made by public health once the cause or etiology is known. In essence, prevention is accomplished through immunization, environmental manipulation, sanitary regulations, specific and general education concerning health, and treatment.

The process is reversed in alcoholism and the problem must be attacked without knowing specific causes. Perhaps there is no single causative factor, but a myriad of factors contributing to this condition. Environment, personality development and the indiscriminate use of beverage alcohol are frequently mentioned as being important, but researchers and scientists have been studying alcoholism through the test tube, chemical metabolism, case histories, personality adjustment, etc. for years with no specific factor or factors being labeled as causative agents. Many theories have been proposed.

Alcoholism is truly a public health problem when applying certain criteria. Theoretically, at least, prevention is possible through education which stresses healthy personality development as well as emphasizes the progressive nature of alcoholism and early recognition of an incipient drinking problem. It can be detected, diagnosed, and treated. There is no doubt that its victims manifest signs of an illness, combining physical and psychological elements, that is widespread. Alcoholism is a public health problem in part, but it is also a combination of many segments of our life that are not easily isolated.

That alcoholism is a public health problem of magnitude is evidenced by its 5 million victims and additional 20 million persons suffering from the effects of this illness.

This article is published by permission of the author, E. Holt Babbitt, who also contributed "What Does It Cost To Be An Alcoholic?" which was published in the July-August, 1961 issue of *Inventory*.

Obviously, it lacks signs of being infectious, hereditary or communicable. However, it might be said that alcoholism is socially contagious or culturally transmitted.

Physicians are well aware of psychological aspects of most illnesses. Alcoholism is no exception. However, two basic differences in this area are readily seen between alcoholism and other illnesses, whether of a public health nature or not.

As opposed to contracting a disease, through a known or unknown carrier, alcoholism is self-induced, meaning the individual brings this about through continued use of alcoholic beverages. Basically, alcohol makes life more tolerable to those who are addicted. The end condition cannot be attributed to any germ or disease-producing organism.

In addition to the deleterious physical aspects of alcoholism, the behavioral factors cannot be overlooked. There are no laws against drinking alcohol or even becoming intoxicated. But legal controls are necessary to regulate what an individual does to himself or others while under the influence. Alcohol is an anesthetic, depressing functions of the brain and acting on the nervous system.

Scorn, ridicule, ostracism, feelings of hopelessness and condemnation are not heaped on those suffering from other physical illnesses. Nor is one's behavior associated with the malady. All people are affected differently through the ingestion of alcohol. This deserves special mention when discussing alcoholics, because it may be difficult or impossible to predict or control their behavior when they are drinking.

Educating the public about public health hazards is not an easy job, nor a "one shot" deal. It involves frequent repetition to get the information across. It's so slow a process that specialists are employed to convey the messages to the public—health educators. Take the problem of rabies control, for example. An annual battle is waged by the professionals to alert the public to dangers of rabid animals, along with proper methods for handling, disposal and treatment, if required.

As an illness, alcoholism is clouded by emotional barriers, both among prospective patients and the public. A certain degree of apathy and disinterest prevails complicated by additional deterrents such as personal bias. A well-recognized axiom of health authorities is that no disease has ever been eradicated solely by treatment. If all alcoholics in the country or in Ohio or Richland County were rehabilitated within a year, it could not really be considered a noteworthy accomplishment unless an intensive alcohol education campaign accompanied various forms of treatment.

Progressive Illness

Alcoholism develops progressively, usually after a long and tortuous period of drinking, during which the incipient problem creeps like a wild vine. So there is a definite need for education and information, both among adults and youths. Effective education among drinking youths might well prevent future addiction, for instance.

When alcoholism is mentioned, automatically implied in people's minds are such other areas as morality, religion, temperance or prohibition, ethics and value judgment. Singularly or in combination, these complicate the psychological and behavioral segments influencing the thinking and attitudes not only of the victim himself, but also his spouse and relatives, employer, physician, clergyman, neighbor and others. For the most part, these factors are absent in mentioning cancer,

hepatitis or food poisoning. Diabetics or polio victims do not get arrested, nor are they denied admission to hospitals for treatment.

Since the founding of Mansfield, Ohio, a city of 50,000 and the business and industrial hub of North Central Ohio, some of its citizens have been using and abusing alcoholic beverages within the usual run of associated problems. In an attempt to combat and help prevent alcoholism, the Mansfield-Richland County Health Department in January, 1962 inaugurated a community-wide alcoholism program. An initial operating grant was provided by the Ohio Department of Health. An outpatient treatment clinic was opened ten months later.

In addition to carrying on a continuing community educational program, data was gathered from agency and court records to determine the extent of the alcoholism problem in the county which has a population of 120,000.

The alcoholism program represented something new for Richland County. Never before had a governmental unit in the county shown such interest in the problem of alcoholism. Never before had it been attacked with such an organized and unified approach. Alcoholics Anonymous had been active there for years and the county Womens Christian Temperance Union for years before that.

As might be expected, some resistance was evident at first and the "trial" alcoholism program was questioned by many, but nearly two years of combining education, community orientation, fact-finding and outpatient treatment indicates, without a doubt, that there is a continuing need for such a program.

In the first year of operation, it was necessary to create a public image of the program and the services it rendered. Alcoholics Anonymous members were assured that this new organization was not designed to compete with their program, but was to supplement their efforts and to cooperate with them as much as possible. A good relationship also had to be established with the many community health and welfare agencies. And finally, it was necessary to inform the general public of the services made available by the program. Talks were delivered to many social and civic groups. Films and slides were also used in addition to the distribution of literature. Personal visits to various key people in the community also contributed to "getting acquainted" with the local people.

The following two examples illustrate the thinking on alcoholism of some individuals in the community. One clergyman in a question-and-answer session at a local ministerial association meeting, inquired if the program took a stand on or advocated total abstinence. Of course, the answer was no. Only in obvious cases involving alcoholic patients whom we are treating is total abstinence recommended.

A visit was made to an adult Sunday school class which A. A. and W. C. T. U. speakers had addressed in earlier sessions. Attention was focused on public health philosophy in alcoholism. The discussion, however, was centered not on the newness of the program and what it offered, but rather on the particular approach to the problem. Several members felt that the alcoholism program should have adopted a firm stand against the use of alcohol. In this area, as with other human problems, attitude changes usually come about through an extremely slow and gradual process.

In the Spring of 1962, the health department sponsored an exhibit on alcoholism at a community health

and safety fair. The reaction of many persons who saw the exhibit is fairly indicative of the predominant attitude and emotionalism toward alcoholism.

Some persons made obvious efforts to cross to the opposite side of the aisle when they aproached the alcoholism exhibit; others kept walking and ignored it. Still others paused and reluctantly accepted educational material. Some flatly refused any of the literature and a few parents were heard to inform their youngsters, who were collecting all the brochures they could carry, that it was better not to take any of this literature.

The clergyman mentioned earlier who was concerned with the program's stand on abstinence might also be interested to know that neither does the program take a stand on social drinking. This is partly public health philosophy and partly based on the approach taken by long-established alcoholism programs. The health department, being a governmental agency, is not in a position to become involved with the morality of drinking or the perennial wet vs. dry controversy. Our tenets do not include influencing individuals to drink or abstain or those who imbibe to drink more or less.

Our philosophy does not condone or condemn the use of alcohol, although our objectivity is sometimes construed to mean the fostering of moderation. We are realistic in believing all the alcoholics in the country will not be rehabilitated nor will social use of alcohol come to an abrupt end.

Our concern is alcoholism, not prohibition. However, we do realize that as long as alcoholic beverages are available, problems will arise, accompanied by many views, attitudes and approaches. Idealistic goals are not always attained. The health department recognizes that alcoholism is a serious problem; it is a problem of contemporary America, hence our efforts to prevent, control and combat it through an enlightened public. The problem is here; we are trying to create an awareness. Over a period of time, a public education program will help lessen the stigma involved in seeking help and people will become aware of the effects of alcohol on body and mind.

Although our approach is that of neutrality, specific messages are conveyed to the public. We are charged with the responsibility of educating and informing residents of our health district, in an objective and unbiased manner, about: (1) the effects of alcohol—what it does and what it doesn't do; (2) danger signs of alcoholism; (3) local sources of assistance for those with a drinking problem; and (4) alcoholism as an illness and health problem.

National Alcoholism Information Week, observed annually, affords a fine opportunity to emphasize this information, but actually, for utmost effectiveness, it should be stressed every week of the year.

When there are five million victims of an illness in this country and when an additional 20 million spouses, children and parents are affected directly through those who exhibit symptoms of the illness, it must be recognized that alcoholism is a public health problem of magnitude. However, the vicious cycle of alcoholism can be broken.

The American public health movement is approximately 100 years old. Emphasis on alcoholism in the United States is but a generation old. There are some fine and well-established community and state alcoholism programs throughout the country, some of which are set up in public health departments. This is one approach to a complex problem which should not be ignored.

The most important stimulus to motivation may well be the creation of a community climate where shame and stigma have been stripped from the illness of alcoholism.

MOTIVATING the ALCOHOLIC to ACCEPT COMMUNITY RESOURCES

BY HERMAN E. KRIMMEL
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WITHOUT an answer to the question, "Why should I stop drinking?", there can be no motivation for the alcoholic to look for or to use even the best community resources. Everything in a discussion of motivation must depend on this basic premise.

If the alcoholic is to be motivated, he must be able to envision a life that is better—more satisfying and more exciting—without alcohol than it is with alcohol. The reason to stop drinking does not have to be the promise of Utopia. It may just be the realization that the everyday life of everyday people, with all its problems, is better than the destructive excitement of excessive drinking.

There will be no progress until the patient accepts the fact that the rewards of sobriety are superior to those of drinking. For most, this discovery does not come quickly or easily. It never comes for some. But the relative, the spouse, the therapist must not easily abandon the effort to bring it about and to recognize the fact that little can be accomplished until the patient's reason to stop drinking is stronger than his reason to continue.

How, then, does one help or motivate an alcoholic to give up one thing —drinking—to achieve another—sobriety? Four major principles constitute the foundation of motivation. They can be expressed in four "Rs" —recognition, relationship, rehabilitation and resources.

Recognition is an area in which we have become the victim of our own cliches. Many of us, for example, accept without question the premise that an alcoholic is unreachable until he recognizes his problem and is ready to ask for help. There is some truth in this, but it is too frequently interpreted to mean that he must always get to this recognition and readiness on his own and

after that we will help him. This apparently means that we sit idly by while the dynamics of the individual somehow arrange themselves in a combination that will propel him to one of the community's helping resources. It can happen this way, of course. But sometimes one gets the impression that the chances are about the same as those of the proverbial monkeys tapping out King Lear by accident if they sit at the typewriters long enough.

This attitude is inconsistent with our dedication to prevention and as you know, everyone worth his salt is for prevention. We have much to learn about prevention. Our knowledge must be expanded and techniques must be refined and sharpened. However, we can agree that it includes recognition of the alcoholic at an earlier stage. But what will it benefit the alcoholic if *we* recognize his problem but *he* doesn't? He still won't do anything about it. In other words—no motivation.

All of which means that someone or something has to actively intervene to motivate him or, at least, to help him motivate himself. I suspect that distinction is semantic. Anyway, if we want to motivate the alcoholic, it means taking direct action.

The alcoholic only recognizes his problem when he hits bottom, not before. But we all know that bottom is at a different level for different individuals. For a small percentage, it may be Skid Row. For one man, it may be the awareness that his teen-age daughter is not inviting her boy friends to her home because she is afraid they will see her father collapsed in a drunken stupor on the living room floor. For another man, it may be the loss of his first job while, for still another, it may be the loss of the tenth job. For one man it may be the day his wife takes the children and leaves and, for another, it may be an arrest for drunken driving. The variations are endless. For each individual, however, bottom is the point at which he says to himself: "If this is what alcohol does to me, I have to stop drinking."

The crisis, whatever it may be, provides the motive to seek help and if, somehow, that crisis can be hastened, it may be less severe and it may send the alcoholic to the helping resource sooner.

The alcoholic must be forced to recognize what alcohol does to him and that unless he does something about it, he will have to face the consequences of his behavior. The passive fellow who uses alcohol to make himself feel like superman, may slap his wife around or brawl in barrooms. These activities may even occur during blackouts, leaving him with no memory of them. But that is no excuse. He has to be told what has happened, what kind of a person he is when drinking, and there must be some insistence that he do something about it.

The wife who has her husband arrested for inflicting physical violence is often overwhelmed by remorse because she feels she has betrayed him. Nevertheless, it may be far better to compel him to face the consequences of his actions immediately than to protect, cover up and wait while he slides deeper and deeper into the more chronic phases of alcoholism. Jail may not be the ideal catalyst, but direct action by the spouse may cause him to hit bottom and the moment of recognition sooner and, as a result, seek help sooner.

One of the problems inherent in the motivation of alcoholics is that, in many cases, the initial contact at an agency or clinic is not with the alcoholic because denial serves him so well that he is the last to recog-

nize his illness. The first contact is frequently with a spouse or relative who must then be helped to motivate the alcoholic. This presents difficulties, but it has to be done. Essentially, it involves strengthening their determination to do what is necessary to compel the alcoholic to face the consequences of his behavior. They have to be convinced that action is almost always better than inaction. They also have to know that any single action may be a calculated risk, because it is impossible to accurately predict at what level bottom will be encountered by any alcoholic, or which crisis will create the need to change.

Sometimes the action has to be drastic; sometimes it doesn't. Frequently the choices for non-alcoholic members of the family are difficult or even seemingly impossible. Sometimes nothing works. But every effort should be made to help families recognize the problem and to do something.

Recognition

It seems to me that we—and I speak especially of practitioners in the so-called helping professions—are cravenly timid in our use of the devices that have the greatest potential effectiveness in the motivation of recognition of the problem. We have used words like *pressure, voluntary, readiness* so glibly that they have lost their meaning. We quite appropriately feel compassion for the alcoholic, but we sometimes allow compassion to keep us from doing the necessary. We need to accept responsibility for direct action to motivate the alcoholic to seek help sooner. The negatives of his drinking behavior may have to be emphasized from the outside so that he will face its consequences and evaluate the assets of sobriety against the liabilities of intoxication.

This may involve the vigorous use of techniques often shunned by therapists. It may, for example, involve the use of exploitation. All too frequently we permit the alcoholic to exploit us in a variety of ways and he is a master at this. However, such submissiveness on the part of the therapist can only operate to the detriment of the patient. We should do the exploiting. We must exploit his most vulnerable and tender spots if we are to make him face the facts of his life sooner.

For one thing, we can exploit his dependency. If an alcoholic is dependent on his family, it may be helpful to confront him with the possibility that he will lose that family unless he does something about his illness. Since most alcoholics seek help from self-interest, they may as well know that they must act if they want to keep their families intact.

The exploitation of guilt seems to be another bugaboo for some professionals. But the alcoholic may be most vulnerable when emerging from the misery of a bender and engaged in tortured self-analysis. What better time to bring him face to face with the effects of his drinking? Many alcoholics describe themselves in words similar to those used recently by one of our patients: "I'm as rotten as they come when I'm drunk." If he is, he should know it although it is equally important to emphasize the fact that he may be a fine person when sober. That may be his motivation for achieving sobriety.

It is true that most alcoholics know how offensive and disreputable their behavior is when they are drinking. However, it has been our observation that they repress or deny this unpleasant memory in sobriety and knowledge must be reinforced by the repeated necessity of facing

the consequences of that behavior until they seek help.

We should never be reluctant to stimulate the discomfort of the alcoholic if it will hasten recognition and action. What seems to be immediate severity may be long-range kindness. Motivation depends on hope for the future, not on excuses for the past.

This brings us to another useful motivational tool—pressure. We have been so dedicated to the proposition that only a voluntary petition for help can produce positive results that we have almost come to regard "pressure" as a dirty word. Essentially, however, most alcoholics seek help under some variety of pressure and, even when it is consciously and vigorously applied, it may be quite beneficial. Certainly the study made by Lemere, O'Hallaren and Maxwell at Shadel Hospital in Washington indicated that we should at least reexamine our traditional belief that alcoholics cannot be forced to stop drinking and that duress is useless in the treatment of alcoholism. They observed that few of the 1,038 patients in the group studied would have sought abstinence unless pressure had been put on them to give up drinking. True, some of the patients who were initially exposed to treatment under protest relapsed, but they later returned of their own volition for successful therapy. It may be especially significant that those patients who came to the clinic under duress did just as well in treatment as those who came voluntarily.

It has been generally accepted, for example, that it is futile to compel an alcoholic to seek help by judicial order. Indeed, many agencies refuse to accept such court referrals because of the compulsion involved. Such refusal fails to recognize the possibility that, by this procedure, some alcoholics might be exposed to treatment just long enough to want to continue. Without that compulsion they might never have reached the clinic. It may be that the number of those who can or will accept help under legal duress is small. But each alcoholic we reach is important. The percentage of the total reached by all resources combined is so small that we cannot ignore *any* possibilty.

The second principle in motivation is relationship. Once the alcoholic has recognized his problem, he may take the next step and that, of course, is to seek help. He may call Alcoholics Anonymous, he may visit his family physician, he may go to a specialized clinic for alcoholics, he may go to a social agency or to his clergyman. That, however, is not the end of our responsibility to motivate the alcoholic. We must not only motivate him to get to a community resource, but to use that resource. Motivation is a continuing process.

Relationship

A vital part of motivation to continue in treatment is inherent in the relationship of the representative of the helping resource to the alcoholic. In A. A. it may be the initial relationship with the sponsor. In the agency or clinic, it is the relationship to the therapist, and it has been our experience that the specific profession of the therapist is not necessarily significant in the relationship. It is the relationship between the patient and therapist as two human beings that has impact.

Acceptance of the patient by the therapist is basic to the relationship. This is not unique to the treatment of alcoholics, but it may assume added importance because it means acceptance of the alcoholic as a worthwhile person rather than simply as a drunk. This may be the

first time in years that he has been so accepted.

We not only accept him as a person but as the victim of an illness that can be treated. Again, however, we must never let him forget that *he* is responsible for doing something about that illness.

Acceptance must never mean that we permit ourselves to be conned or deceived because alcoholism is an illness that promotes that kind of activity. It is no service to the alcoholic to pretend you believe him when you know perfectly well that he is lying.

Alcoholics Anonymous has, of course, effectively developed the use of acceptance. As John Park Lee has said of a new member of A. A.: "No one asks him where he has been; no one asks him if he is sorry; no one suggests that he ought to be ashamed of himself." Many recently recruited members of A. A., he adds, say they feel as if they have joined the human race again.

This, incidentally, does not conflict with the principle of using such devices as guilt to stimulate recognition. After recognition has been achieved and the alcoholic has taken the next step, it is then possible for him to move forward and looking backwards becomes unnecessary.

If recognition leads to relationship, then the motivation to use community resources will endure only if the relationship is linked to *rehabilitation,* the third principle. This means that the *immediate* goal of rehabilitation must be to help the alcoholic stop drinking and to see the possibility of other satisfactions quickly. A. A. accomplishes this goal most effectively by insisting that the alcoholic take the first of twelve steps which is also the first rung on the ladder of hope which will enable him to climb to a healthy, productive life.

Other helping resources must also learn to provide a glimpse of immediate satisfactions which oil the machinery of motivation. To lose sight, even momentarily, of the goal of sobriety is to risk the loss of motivation that has been achieved up to this point.

There are many treacherous lures for the unwary therapist. We are often beguiled by the sweetly singing sirens of causation and diagnosis, but they must be resisted in the beginning or the patient is lost. A social worker recently declared that it is not enough to say that a person is an alcoholic because "it does not tell us very much about a person or his real problems. . ." "It is," he continued, "no more of a diagnosis to describe someone as an alcoholic than it would be to call someone maladjusted or delinquent." Perhaps it doesn't say much, but it is a beginning. If a person calls himself an alcoholic, he is saying that he is drinking to the extent that he is continuously damaging some part of his life and he had better stop drinking. He may have a dozen other problems, but he isn't likely to be able to cope with them until he can see them clearly and does not have to find refuge in the bottle.

Dr. Harry Tiebout has observed that even the best equipped psychiatrist may fail with alcoholics because he is steeped in the methods of modern medicine which means that when you encounter an illness, you search for the cause, then you treat the cause and cure the illness.

"When a person so oriented hits alcoholism," says Tiebout, "he is out-of-luck, only he does not know it. What happens is that he bypasses the disease and looks for causes; he ends up talking about earlier experiences and never gets close to this patient or the illness . . . his training is a hindrance rather than a help.

He must revamp his sights, or he is lost."

Goals and satisfactions can be provided in agencies and clinics, and it is our experience that the patient must be given something in the first interview. It may be a realistic approach to sobriety itself. It may be concrete reassurance that a man is or can be a good husband, a good father, a good employee. It may be something tangible like antabuse or medication to alleviate the shakes. It may be simply the hope that next week will be better because he will have been sober for a few days and will have been able to sample some simple joys. One patient told us in amazement that since he had stopped drinking, "food tastes like food again."

Resources

Any discussion of motivation of the alcoholic to accept community resources must have a dual focus which brings us to the fourth principle in motivation — the *resources* themselves. Only half the job is accomplished if we persuade the alcoholic to accept these resources unless we also motivate the community resources to accept the alcoholic. We can develop techniques that arouse in every alcoholic the urgent desire to seek immediate help, but if the doors of agencies, churches and hospitals remain closed, our efforts will fail.

Much, of course, has been done to open some of these doors. To bolster our optimism, we have only to review the work of the National Council on Alcoholism during the past two decades. We can add to this the powerful influence of Alcoholics Anonymous, the efforts of the North American Association of Alcoholism Programs with government supported alcoholism agencies, the official recognition by the American Medical Association of alcoholism as an illness and the participation of the federal government with funds and personnel in the battle against this major public health problem.

There are additional listings in the catalogue of success, but not nearly enough. Much remains to be done. We cannot afford complacency as long as damaging myths and prejudices about alcoholism persist. Two of us from the Cleveland Center on Alcoholism recently participated in a radio program which invites listeners to telephone their questions to the guests. Many called to proclaim their own pet theories, a majority of which were rooted in prejudice rather than knowledge. Alcoholics, they declared, are weak; alcoholics should know better than to leave their wives and children for the brotherhood of the bar; alcohol is Satan's brew, etc. One woman said she came from a small dry community where no one had personal problems because no one drank. She was outraged when I suggested that every human being has some problems. Let them stop drinking and they won't, she insisted.

These are extremes? Perhaps. But they reflect thinking that is still far too prevalent.

It may well be that the most important stimulus to motivation will be the creation of a community climate where shame and stigma have been stripped from the illness of alcoholism. Only then will its victims be able to employ their motivation to seek help constructively because it will be possible for them to admit, without fear of recrimination, that they are alcoholics and need help.

Moreover, we must create especially a professional community climate in which the alcoholic can obtain help where he asks for it. If he goes to a social agency, he can and should

be helped there. He must not be told that this is primarily or exclusively a medical problem and to go see a physician. Indeed, the chances are that if he does go to a physician, he may be told that he should really see a psychiatrist because alcoholism is only the symptom of deeply imbedded emotional disorders requiring the talents of a latter day Sigmund Freud. So the buck—or the alcoholic in this case—is passed from one place to another until he probably decides that it is just too much trouble and he might as well go on drinking.

We talk about the need for alcoholics to have a knowledge of community resources, but we had better be sure that when he is ready to use this knowledge, the resources are ready to help him.

One of the most impregnable walls between the alcoholic and help is the misconception that there is one best way to help alcoholics. Equally discouraging is the misconception that just because one method doesn't help there is no hope. Many clinic patients have previously tried A. A. which for them did not work, but they do find the necessary help in a casework or counselling or psychotherapeutic relationship. Others have tried a clinic, a social agency, and found the methods wanting for them, but they succeed in A. A. Some use both resources simultaneously. Alcoholics are first of all individual human beings and different individuals have different needs. In all efforts to motivate the alcoholic, this should be kept in mind.

We have much to learn about the techniques of motivation. There are no simple answers for such complex subjects as men and women. But we have learned from experience, and we should not be afraid to use what we know while we continue to test, to experiment and to refine.

POSITIVE STAFF ATTITUDES

CONTINUED FROM PAGE 18

ond theme is to say that treatment consists not only of a medical regimen but also of the context in which the regimen is carried out. Thus all members of a hospital staff are part of a treatment team, maintaining an atmosphere at all times in which the recovery of the patient is facilitated. It is easy to overlook the importance of this therapeutic milieu in the treatment of tuberculosis. We forget that less than fifty years ago it was necessary to change staff attitudes toward acceptance of tuberculosis as a disease with no moral overtones. We now must create a therapeutic milieu for the alcoholic tuberculous patient which is such that his efforts toward recovery are consistently fostered by all staff members at all times—one in which any staff member can answer questions or provide support in a realistic and accepting manner in times of crisis as well as from day to day. This means, from a practical standpoint, that as we plan for treatment, we must out of sheer necessity first indoctrinate the staff through extensive inservice education on alcoholism. This includes all members of the staff from the medical team all the way down through the organizational structure.

Alcoholism is *not* different from other chronic illnesses. Alcoholics *can* be helped to recover. It is my firm conviction that we have in our hospitals the treatment personnel capable of doing the job. This means that professionals need to see how they can change their roles for greater treatment effectiveness. It will mean some uneasy feelings about change; and the initiation of social change within a total institution must occur slowly if change is to result in positive effectiveness.

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for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

— Outpatient Treatment Services

ASHEVILLE—

**Educational Division, Board of Alcohol Control;* Don Dancy, Educational Director; Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Montlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone: TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone 834-6484; Hours Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St. P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

†*Moore County Mental Health Clinic, Inc.;* Box 1098; Phone: 695-7781.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM

*†*Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

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